Make-vs.-Buy Case Study: The Defense Health Program and TRICARE Management Activity

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Agenda

- Background: Size of the Defense Health Program
- The make versus buy decision--sizing in-house care
  - Wartime mission and peacetime missions
  - Relative cost of care
  - Controlling beneficiary behavior
  - New TRICARE for Life Benefit complicates incentives
  - Conclusions
- Ongoing make versus buy decisions--How well does DoD Make or Buy?
  - Beneficiaries pushed out onto more expensive TRICARE contracts
  - Root causes of perverse incentives

Size of the Defense Health Program

- $24.9B in FY 02 to run total system
- 130,000 personnel (military and civilian)

DoD Medical Treatment Facilities (MTFs)

- $10.4B to run hospitals and clinics
- 76 hospitals and medical centers
- 513 clinics

Purchased Care

- $10.0B in purchased care
- 14 TRICARE regions
- 7 TRICARE regional contracts
- Some non-TRICARE purchased care

Other programs: Education and Training ($1.3B), Consolidated Health Activities ($1.2B), IM/IT ($.6B), RDT&E ($.5B), Management ($.3B), Procurement ($.3B) and Milcon ($.2B)

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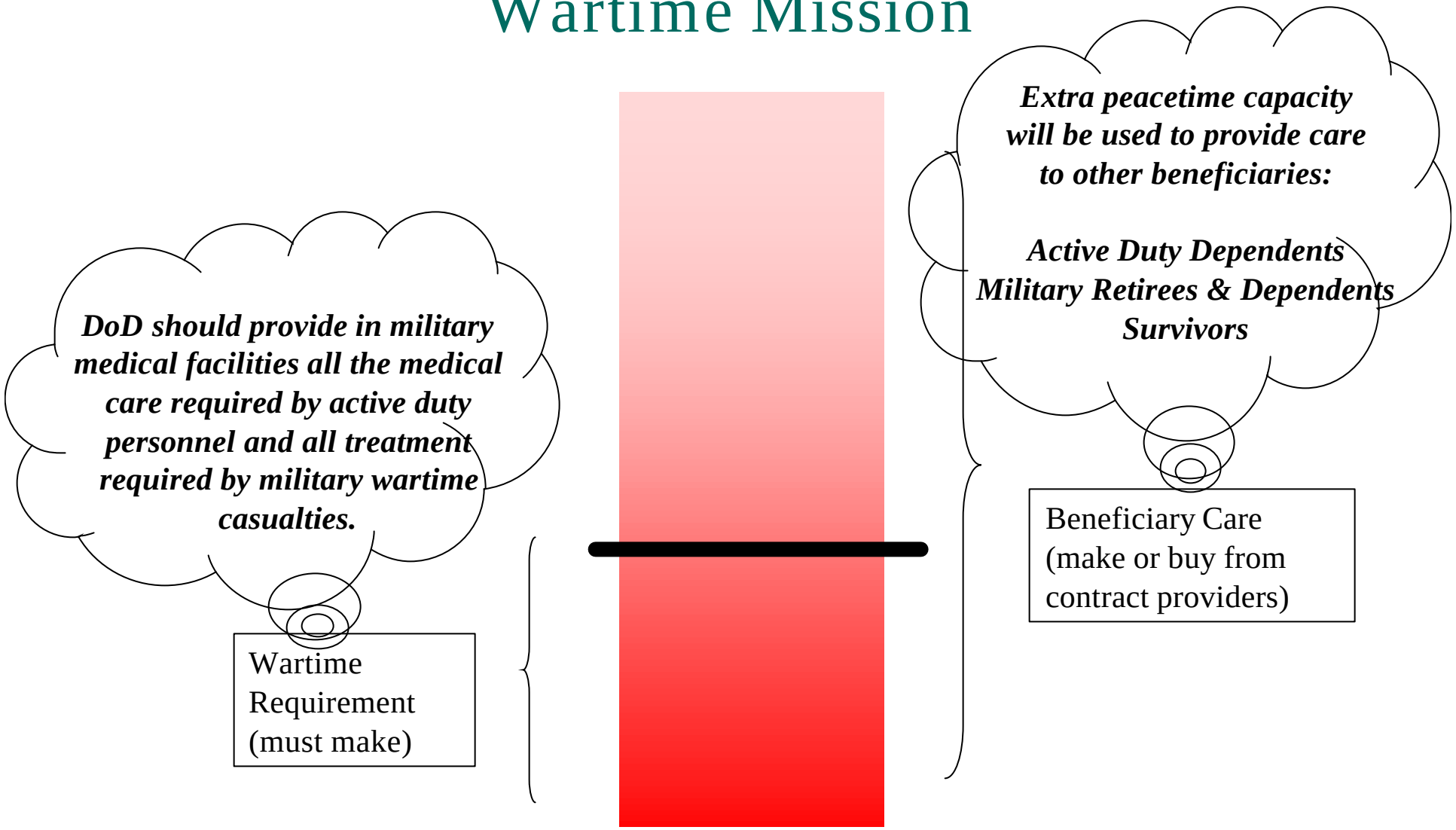
Policy Guidance to the 733 Update Study for Sizing the Post-Cold War Medical Establishment

- All active duty care provided or arranged by military physicians
- Wartime casualties cared for in military facilities until return to duty or discharged to VA for any further care
  - » Implication: MTFs must be at least large enough to care for wartime casualties
- Beyond wartime requirements, provide care in MTFs to the extent it is cost effective
  - » Additional peacetime care to dependents and retirees provided through TRICARE by private sector providers

Benefit Mission is Much Larger than Wartime Mission



The Total Number of DoD Physicians Exceeds the Requirement

	# of Physicians
• Wartime Requirement[1]	4,465
• Sustainment and Training Total	4,532
• Total Physician Base Requirement	8,997
• Physician Total	11,846
• Total as Percent of Base Requirement	132%

Source: 733 Update Study - April 1998

1. Excluding CONUS casualty care (counted in sustainment and training total)

Can a Larger Medical Establishment Be Justified?

- Justification rests on economic grounds.
  - Does DoD have a cost advantage?
  - Can DoD exploit its cost advantage if it has one?

Two Studies Found MTF Case Mix Adjusted Costs To Be Less Than the Costs of Purchased Care

- IDA (1994) found purchased care 33 percent more expensive than the cost of MTF care
- CNA (2001) found purchased care to be 47-65 percent more expensive than the cost of MTF care

Sources: *Cost Analysis of the Military Medical Care System,* IDA 1994, and *Efficiency Analysis of Military Medical Treatment Facilities,* CNA, 2001.

Why Does DoD have a Cost Advantage?

- Don’t fully understand all of the reasons for the advantage
  - » IDA found that about 38 percent of the cost advantage came from two items:
    - – DoD spends little for indigent care; and
    - – spends much less on facilities construction
  - » 42 percent of the cost advantage is accounted by the profits earned by private sector providers and the cost of their liability insurance
- Most savings accrue to the beneficiary
  - » savings to the government are about half of the total

Cost Advantage Cannot Be Exploited Without Enrollment

- DoD program generally lacks controls such as premia, copayments, deductibles, and enrollment
- Increases in capacity attracts people from TRICARE contractors plus those currently using private insurance.
- DoD saves money on the difference between DoD costs and contractor costs--but loses money on the whole cost of treating new users.
- Therefore, a relatively small number of new users is sufficient to tip the balance against “making” care.

TRICARE for Life and the Make Versus Buy Decision

- TRICARE for Life gives the TRICARE Benefit to Medicare-eligible retirees and dependents
  - » If care is received in DoD facilities, DoD pays
  - » If care is received from a private sector provider, MEDICARE pays up to MEDICARE limits, DoD pays up to TRICARE limits (about 20%)
- Net effect--Less costly for DoD if care received outside DoD facilities.

Conclusions on Make Versus Buy

- Costs would be reduced by bringing work into the MTFs from the contracts (but not Medicare-eligible beneficiaries or new users).
- Free care in the MTF, plus a lack of controls on beneficiaries, make exploiting the cost benefit very difficult.
- Under these circumstances, the least cost solution likely to be:
  - » size to the wartime requirement; and
  - » buy remaining care.

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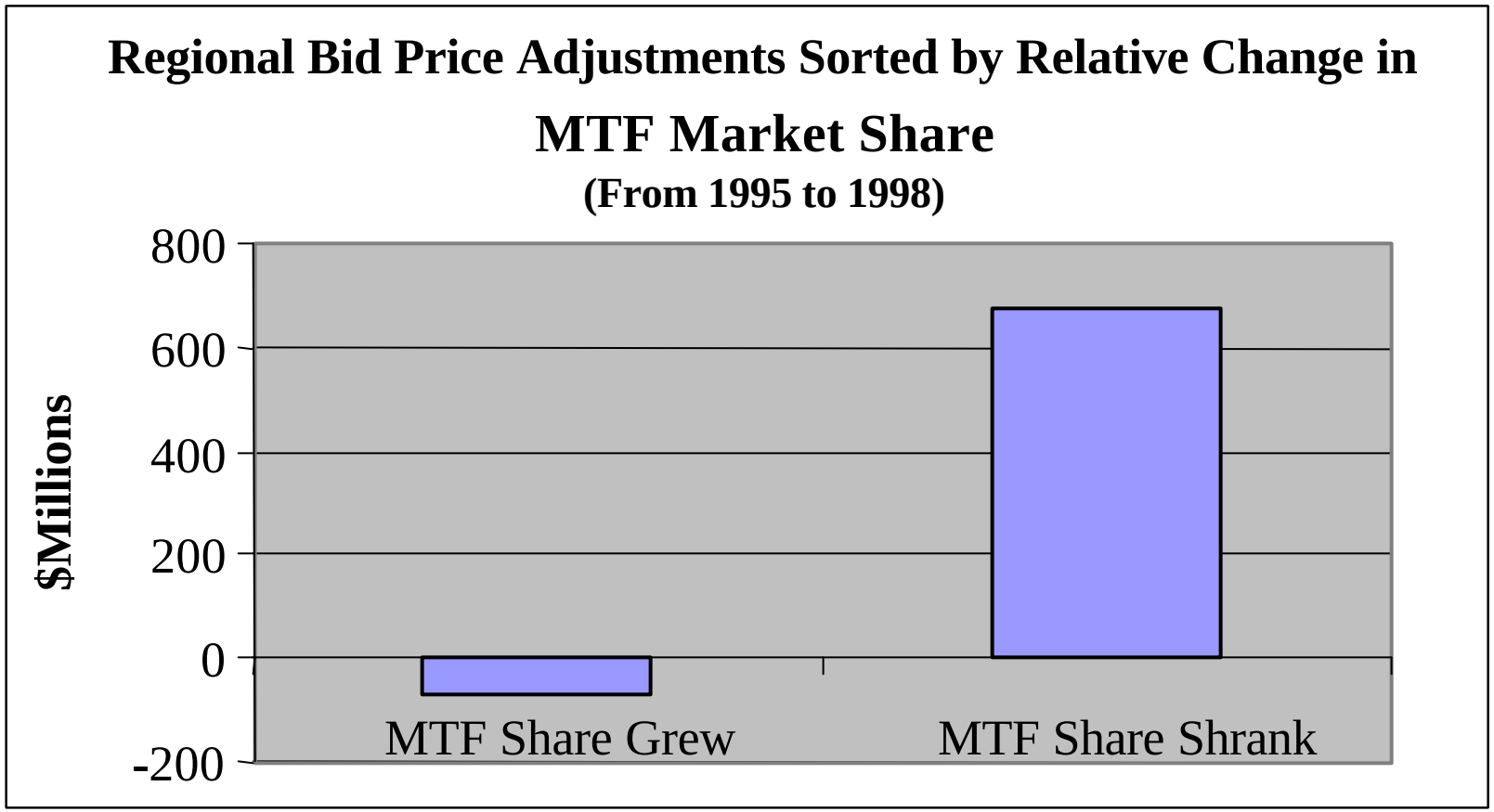
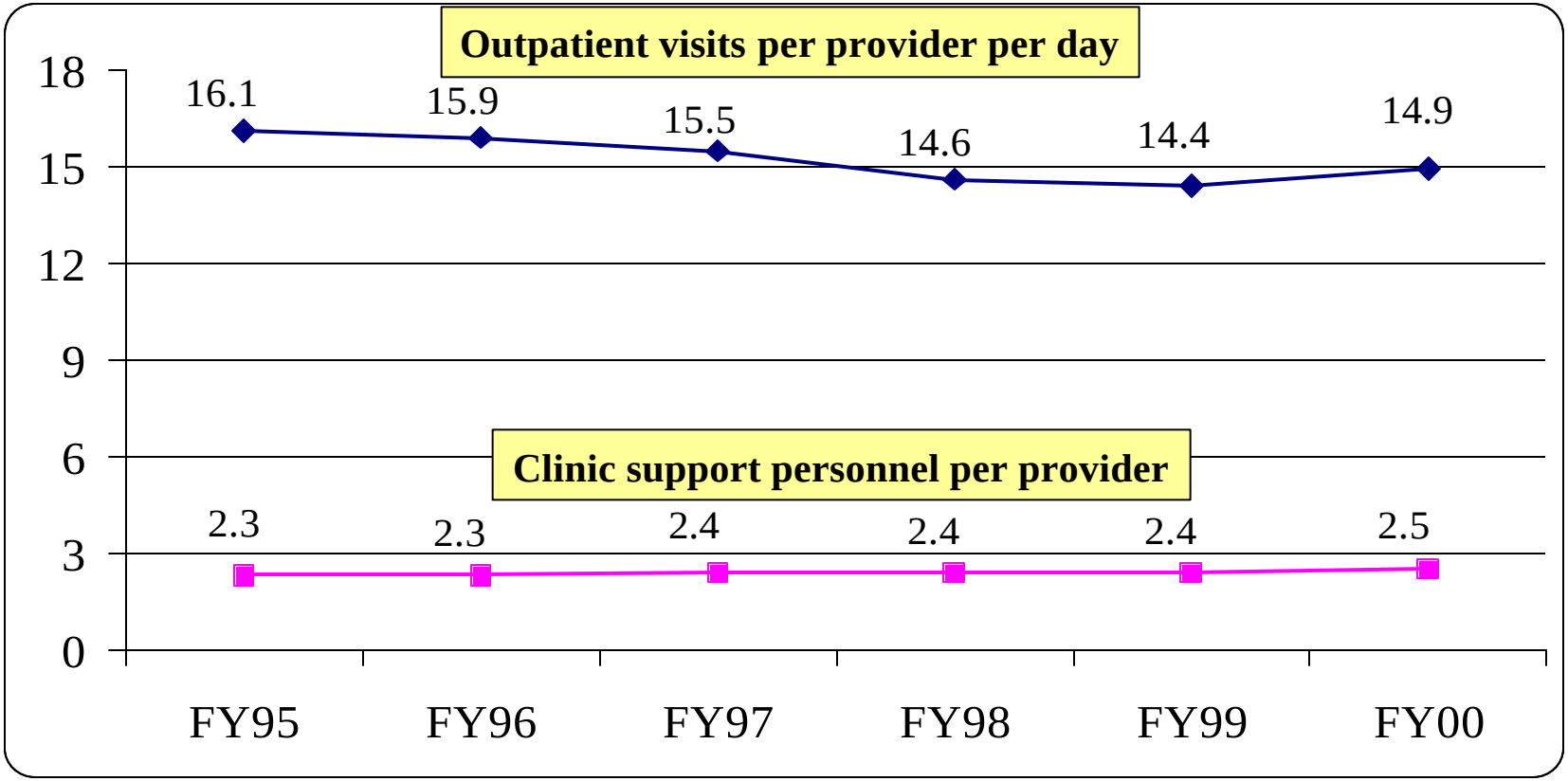
Why MTF Utilization is Important to Purchased Care Cost



MTF Productivity Fell Between FY95 and FY99



Financial Incentives for MTF Commander Under Current System

- Funding for MTF is dependent upon historical funding with adjustments for
  - » Changes in MTF enrollment from expected levels
  - » New activities/responsibilities
  - »In TRICARE 2.0, a small portion of MTF funding is based on the number of enrollees at the MTF[1]

- MTF funding maximization strategy--enroll beneficiaries in the MTF, but send to the contractor for treatment.
  - » Enrollment increases budget;
  - » Reportedly, MTF frequently not billed for purchased care for enrollees (despite provisions in Version 2 of the TRICARE contracts)

- Second best funding strategy--limit enrollment
  - » MTF avoids entire cost of care;
  - » Only partially offset by funding reduction

[1] Incentives in version 1 are worse.

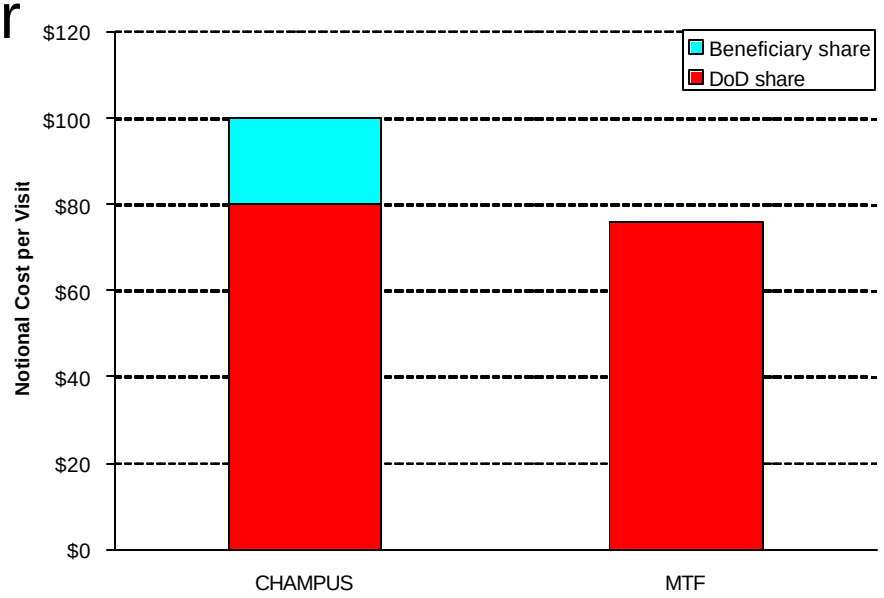
Root Causes Of Perverse Incentives?

- DoD has attempted to overlay a managed care system (TRICARE) on an older system
  - » Inappropriately designed and ineffective financial and accounting systems
  - » Fractured command and control system--weak oversight of make versus buy decisions

Backup

MTF Care is Cheaper per Episode

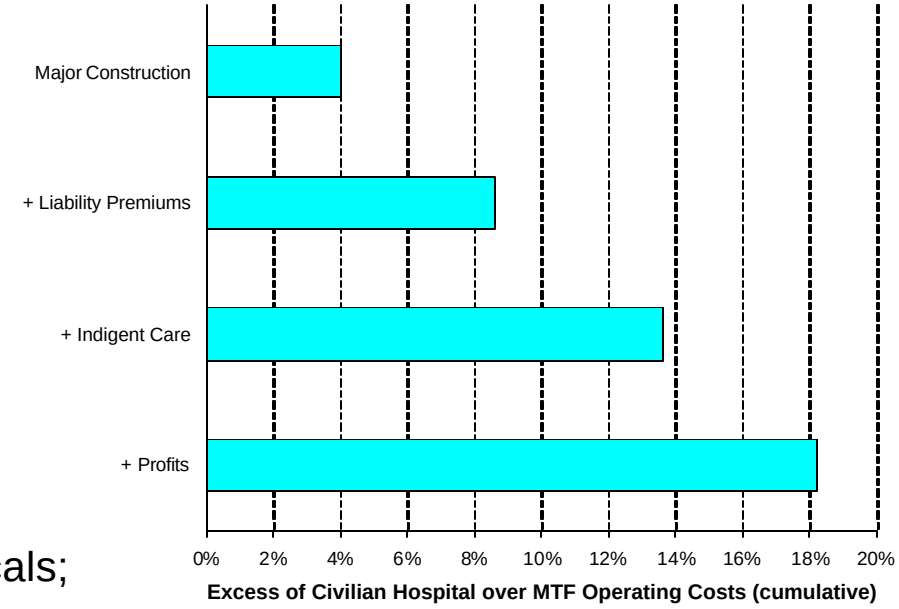
- MTF care is about 25% cheaper per case than purchased care.
- Saving mainly accrues to beneficiaries, who avoid co-pays and deductibles.
- DoD budget saving ~5% per case on average.



Source: 733 Study

External Validation of MTF Unit-Cost Advantage--1994 Estimates

- Unit-cost advantage based on comparison of MTFs to CHAMPUS.
- External validation based on analysis of American Hospital Association (AHA) and other civilian-sector data.
  - »additional cost elements that DoD would have to pay to purchase care.
- Still other cost elements, more difficult to quantify:
  - »lower physician salaries at MTFs (even including bonuses);
  - »MTFs enjoy quantity discounts on large purchases of supplies, e.g., pharmaceuticals;
  - »MTFs avoid taxes and tax preparation expenses.



Source: 733 Study

Virtual Hospital Efficiency
Government Costs Only

Even when compared to just the government's costs for purchased care, MTFs are still less expensive than the purchased-care alternative

	Total ratio	Gov't-only ratio
1997	**1.65**	**1.31**
1998	**1.45**	**1.17**
1999	**1.47**	**1.21**

$$\text{Government-only ratio} = \frac{\$ \text{ (government cost for purchased care)}}{\$ \text{ (actual MTF cost)}}$$

Sources: ***Efficiency Analysis of Military Medical Treatment Facilities,*** **CNA, 2001**

DoD Beneficiaries--FY2002